Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

PLAZA MEDICAL CENTER OF FT WORTH
10030 N MACARTHUR # 100
IRVING TX 75063

Respondent Name:
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-12-1172-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see attached Billing. All services were following back pain post spinal procedure. The doctors noted her condition at the time services were rendered. No payment was made By carrier."

Amount in Dispute: $50,418.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Department of Insurance Division of Workers Compensation rendered a decision that the compensable injury of 10/11/2010 does not extend to include lumbago and urinary retention. Please see the attached Decision and Order dated 8/29/11 Docket No FW-11-132690-01-C-FW46. ."

Response Submitted by: Liberty Mutual, 303 Jess Jewell Parkway SE, Ste. 500, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2010 through December 20, 2010	Hospital Inpatient Services	$50,418.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §133.250 sets out the procedures for health care providers to submit workers' compensation medical bills for reconsideration.
4. The services in dispute were denied by the respondent with the following reason code:

   Explanation of benefits dated March 10, 2011:

   - W12 – X206 – The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit appeal with EOP and documentation to support the relatedness of services rendered to the work related injury.

Issues

1. Did the Requestor submit a request for reconsideration for the services in dispute in accordance with 28 Texas Administrative Code §133.250?
2. Is the Carriers denial reason supported?

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(c)(2)(A) the Requestor has not provided documentation to support that a request for reconsideration was made in accordance with 28 Texas Administrative Code §133.250.

2. The insurance carrier denied disputed services with reason code "W12 – X206 – The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit appeal with EOP and documentation to support the relatedness of services rendered to the work related injury." A contested case hearing was held to address issue of extent of injury, or liability and a final decision on the matter was issued on August 29, 2011, which held, in pertinent part, that "The compensable injury of October 11, 2010 does not extend to and include lumbago and urinary retention." Review of the submitted documentation finds that the admitting diagnoses was "Back pain with urinary retention status post spinal procedure, rule out cauda equine versus epidural abscess." The Division concludes that the disputed services were not rendered in treatment of the injured worker's compensable injury. The respondent's denial reasons are supported. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 6, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		January 6, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.